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| **https://tinyurl.com/ycag48hs2 week Urgent Referral for Suspected Head & Neck Cancer (*ex*cluding Thyroid)** | |
|  | v4.6 EMIS Web December 2016 |

Please email to   **PCC2wwOxford@nhs.net** and request a Read Receipt when sending

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| Patient’s details | | | | | Patient’s background and culture | | | |
| Surname | | Surname | | | Ethnicity | | Ethnic Origin | |
| Forename | | Given Name | | | 1st language | | Main Language | |
| Known as | | Calling Name | | | Interpreter required? Y  N | | | |
| DOB | | Date of Birth | Age | Age |  | | | |
| Sex | | Gender | | | GP details | | | |
| Title | | Title | | | Referring GP |  | | |
| Address & postcode | | Home Full Address (single line) | | | GP address | Organisation Name  Organisation Full Address (single line) | | |
|  | |  | | | GP Tel no | Organisation Telephone Number | | |
| NHS No | | NHS Number | | | GP Fax no | Organisation Fax Number | | |
| Hospital No | | Hospital Number | | | Practice Email | Organisation E-mail Address | | |
| Home tel | | Patient Home Telephone | | | Referral date | Short date letter merged | | |
| Work tel | | Patient Work Telephone | | | Date received |  | | |
| Mobile tel | | Patient Mobile Telephone | | |  |  | | |
| Email | | Patient E-mail Address | | |  |  | | |
| Patient’s preferred contact number | | | | | Home | Work | | Mobile |
| Patient agrees to telephone message being left? | | | | | Yes | No | |  |
| Dentist details (if known) | | | | | | | | |
| Name |  | | | | Telephone | |  | |
| Practice |  | | | | Fax | |  | |

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| **2ww referral communication checklist**  **it is essential that you answer all questions in this section** | | |
| I have explained to the patient that they may have cancer and I am  referring them on the 2 Week Wait Suspected Cancer Pathway | Yes | No – why not? |
| Is the patient available for an appointment within the next 14 days? | Yes | *NB. Please only submit this referral when the answer is* ***Yes*** |
| Has the patient been given the Fast Track Pathway information leaflet?  Information leaflets can be printed from here <https://tinyurl.com/ycag48hs> | Yes | No – why not? |
| **IMPORTANT:**  **Please ensure this patient is available from referral for further hospital appointments and investigations.**  **Failure to check this may result in wasted appointments.**  **If the patient cannot attend immediately (e.g. booked travel) please negotiate a delay in referral.**  **Please indicate any exceptional circumstances here** | | |
| I have explained to the patient that, to ensure they are seen within  14 days, appointments may be offered at either Oxford or Banbury | Yes | No – why not? |
| **Once cancer has been excluded the patient will be referred back to you, their GP**, other than in exceptional  circumstances where immediate onward referral is deemed clinically necessary by the secondary care clinician | | |

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| **Referral Criteria** | | |
| Your patient is **Age** old | | |
| Salivary Gland | Suspected cancer; please give details |  |
| Maxillary Sinus | Suspected cancer; please give details |  |
| Nasal | Suspected cancer; please give details |  |
| Post Nasal Space | Suspected cancer; please give details |  |
| Oral | **For Oral symptoms NICE recommends urgent dentist referral first but**  **if not practical, use 2-week wait pathway if concerned** | |
| Ulceration in oral cavity > 3 weeks |  |
| Persistent lump in neck |  |
| Lump on lip or oral cavity |  |
| Red, or red and white, patch in oral cavity |  |
| Neck | Suspected cancer; please give details |  |
| Larynx | Age 45 and over with persistent unexplained hoarseness |  |
| Age 45 and over with unexplained lump in neck |  |
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| Tonsil/tongue base | Unilateral sore throat |  |
|  | Unilateral Otalgia |  |
|  | Tonsillar enlargement/ulceration |  |

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| **Management of patients who are receiving anticoagulation**  Information required to allow the most patients to move ‘straight to test’ prior to OPA  Failure to supply this information may delay their progress and result in unnecessary appointments | |
| This patient IS NOT anticoagulated |  |
| This patient IS anticoagulated with |  |
| Reason for anticoagulation |  |
| Had an INR of  On | (Date) |
| History of bleeding disorder |  |

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| **Please add a referral letter / additional information for clinical use**  (please highlight any significant comorbidities)  Failure to provide clinical information may result in delayed treatment | |
|  | **Please tick here if you are sending any additional documents**  The referral narrative should be typed onto this form, not in a separate letter |
|  | **Please tick here if the patient *does not meet* the 2 week wait criteria** but you feel they still warrant urgent investigation under this pathway, and outline the details below  This referral will then be triaged by the specialist prior to acceptance |
| **Please type your clinical referral here:** | |

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| **Additional patient information** |  | |
| **Coded data** | **Manually entered if not autopopulated** | |
| Specific Codes Table: FH: Neoplasm - \*... | Family history of any cancer | |
| Smoking | Never smoked |  |
|  | Past smoker |  |
|  | Current smoker |  |
| Alcohol Consumption | Alcohol consumption       units per week | |

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| **Performance Status Key**  (to be **completed by GP** to assist provider with booking an appropriate clinic appointment)  Failure to provide this information may lead to a wasted appointment | | |
| **Fully active**, able to carry on all pre-disease performance without restriction | **0** |  |
| **Restricted in physically strenuous activity** but ambulatory and able to  carry out light/sedentary work, e.g. house or office work | **1** |  |
| Ambulatory and capable of self care, but **unable to carry out work activities**  Up and active > 50% of waking hours | **2** |  |
| **Capable of only limited self care**. Confined to bed or chair >50% of waking hours | **3** |  |
| **Completely disabled**. Cannot carry out any self care. Totally confined to bed or chair | **4** |  |

Consultations

Problems

Medication

Allergies